MINIMUM DATA SET (MDS) — VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME®					
		a. (First)	b. (Middle Initial)	c. (Last)	d. (Jr/Sr)	
2.	GENDER®	1. Male	2. Female			
3.	BIRTHDATE®	Month		Year	-	
4.	RACE/⊛		ndian/Alaskan Native	4. Hispanic		
	ETHNICITY	2. Asian/Pacif		5. White, not of Hispanic orig	in	
5.	SOCIAL	a. Social Sec	. Social Security Number			
	SECURITY®					
	AND MEDICARE					
	NUMBERS®	b. Medicare n	Medicare number (or comparable railroad insurance number)			
	[C in 1st box if					
	non med. no.]					
6.	FACILITY	a. State No.	State No.			
	PROVIDER NO.®					
		b. Federal No.				
7.	MEDICAID					
	NO. ["+" if pending, "N+"					
	if not a					
	Medicaid					
	recipient]€					
8.	REASONS	[Note—Other	codes do not apply to this f	form]		
	FOR ASSESS-		ason for assessment			
	MENT		ion assessment (required b	by day 14)		
			Annual assessment Significant change in status assessment			
			ant correction of prior full as			
		Quarter	ly review assessment			
			ant correction of prior quart	erly assessment		
		U. NONE	OF ABOVE			
			assessments required fo	or Medicare PPS or the	State	
			re 5 day assessment re 30 day assessment			
			re 60 day assessment			
		4. Medica	re 90 day assessment			
			re readmission/return asse	essment		
			tate required assessment re 14 day assessment			
			ledicare required assessm	ent		

9.	Signatures of Persons who Completed a Portion of the Accompanying Assessment o Tracking Form
	+

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
ī.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

MDS MEDICARE PPS ASSESSMENT FORM (VERSION JULY 2002)

AB5.	RESIDEN-	(Check all settings resident lived in during 5 years prior to date of entry.)	
	TIAL HISTORY	a. Prior stay at this nursing home	
	5 YEARS PRIOR TO	b. Stay in other nursing home	
	ENTRY	Other residential facility—board and care home, assisted living, group home	
		d. MH/psychiatric setting	
		e. MR/DD setting	
• •		f. NONE OF ABOVE	
A1.	RESIDENT NAME		
		a. (First) b. (Middle Initial) c. (Last) d. (Jr	
A2.	ROOM NUMBER		
A3.	ASSESS- MENT	a. Last day of MDS observation period	
	REFERENCE DATE		
	DAIL	Month Day Year	
A4a	DATE OF REENTRY	Date of reentry from most recent temporary discharge to a hospita last 90 days (or since last assessment or admission if less than 90	l in
	KLLIVIKI	days)	
		Month Dav Year	
A5.	MARITAL	1. Never married 3. Widowed 5. Divorced	
A6.	STATUS MEDICAL	2. Married 4. Separated	
	RECORD NO.		
		(For those items with supporting documentation in the medical	
A10.	ADVANCED DIRECTIVES	record, check all that apply)	
		b. Do not resuscitate c. Do not hospitalize	
B1.	COMATOSE	(Persistent vegetative state/no discernible consciousness)	
		No 1.Yes (If Yes, skip to Section G) (Recall of what was learned or known)	
B2.	MEMORY	a. Short-term memory OK—seems/appears to recall after 5 minutes	
		Short-term memory OK—seems/appears to recall after 5 milliones O. Memory OK 1. Memory problem	
		b. Long-term memory OK—seems/appears to recall long past	
		0. Memory OK 1. Memory problem	
B3.	MEMORY/ RECALL	(Check all that resident was normally able to recall during last 7 days)	
	ABILITY	a. Current season d. That he/she is in a nursing home	
		b. Location of own room e. NONE OF ABOVE are recalled	
B4.	COGNITIVE	c. Staff names/faces (Made decisions regarding tasks of daily life)	
D4.	SKILLS FOR	INDEPENDENT—decisions consistent/reasonable	
	DAILY DECISION-	MODIFIED INDEPENDENCE—some difficulty in new situations	
	MAKING	only 2. MODERATELY IMPAIRED—decisions poor; cues/supervision	
		required	
		SEVERELY IMPAIRED—never/rarely made decisions	
B5.	INDICATORS OF	(Code for behavior in the last 7 days.) [Note: Accurate assessment requires conversations with staff and family who have direct knowledge.]	ledae
	DELIRIUM— PERIODIC	of resident's behavior over this time].	-
	DISOR-	Behavior not present Behavior present, not of recent onset	
	DERED THINKING/	Behavior present, over last 7 days appears different from resident's us	sual
	AWARENESS	functioning (e.g., new onset or worsening)	
		a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)	
		b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF	
		SURROUNDINGS—(e.g., moves lips or talks to someone not	
		present; believes he/she is somewhere else; confuses night and day)	
		c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is	
		incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)	
		d.PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin,	
		clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)	
		e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into	
		space; difficult to arouse; little body movement)	
		f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE	
		DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)	

C4.	MAKING			
	SELF UNDER-	0. UNDERSTOOD		
	STOOD		—difficulty finding words or finishing	
		thoughts		
		2. SOMETIMES UNDERSTO concrete requests	OOD—ability is limited to making	
		3. RARELY/NEVER UNDERS	STOOD	
C6.	ABILITY TO	(Understanding verbal information		
C6.	UNDER-	l '	ilon content—nowever able)	
	STAND	0.UNDERSTANDS	-may miss some part/intent of	
	OTHERS	message	—may miss some parvintent or	
		-	DS—responds adequately to simple,	
		direct communication		
Ш		3.RARELY/NEVER UNDERST		
D1.	VISION	(Ability to see in adequate light	,	
		 ADEQUATE—sees fine deta newspapers/books 	il, including regular print in	
			t, but not regular print in newspapers/	
		books	, sat not regular print in newspapers	
		2. MODERATELY IMPAIRED—	-limited vision; not able to see	
		newspaper headlines, but ca		
			identification in question, but eyes	
		appear to follow objects	vision or sees only light, colors, or	
		shapes; eyes do not appear		
E1.	INDICATORS	(Code for indicators observed in las	st 30 days, irrespective of the assumed cause)	
	OF	Indicator not exhibited in last		
	DEPRES- SION.	1. Indicator of this type exhibite	ed up to five days a week	
	ANXIETY,	Indicator of this type exhibite	d daily or almost daily (6, 7 days a week)	
\vdash	SAD MOOD	VERBAL EXPRESSIONS	h. Repetitive health	
		OF DISTRESS	complaints—e.g.,	
		a. Resident made negative	persistently seeks medical attention, obsessive	
		statements—e.g., "Nothing	concern with body functions	
		matters; Would rather be dead; What's the use;	i. Repetitive anxious	
		Regrets having lived so	complaints/concerns	
		long; Let me die"	(non-health related) e.g., persistently seeks attention/	
		b. Repetitive questions—e.g., "Where do I go; What do I	reassurance regarding	
		do?"	schedules, meals, laundry, clothing, relationship issues	
		c. Repetitive verbalizations—	SLEEP-CYCLE ISSUES	
		e.g., calling out for help, ("God help me")	j. Unpleasant mood in	
		' '	morning	
		 d. Persistent anger with self or others—e.g., easily 	k. Insomnia/change in usual	
		annoyed, anger at	sleep pattern	
		placement in nursing home; anger at care received	SAD, APATHETIC, ANXIOUS APPEARANCE	
		e. Self deprecation—e.g., "I	I. Sad, pained, worried facial	
		am nothing; I am of no use	expressions—e.g., furrowed brows	
		to anyone [™]	m. Crying, tearfulness	
		f. Expressions of what appear to be unrealistic	n. Repetitive physical	
		fears—e.g., fear of being	movements—e.g., pacing, hand wringing, restlessness,	
		abandoned, left alone, being with others	fidgeting, picking	
		g. Recurrent statements that	LOSS OF INTEREST	
		something terrible is about	o. Withdrawal from activities	
		to happen—e.g., believes he or she is about to die,	of interest—e.g., no interest	
		have a heart attack	in long standing activities or being with family/friends	
			p. Reduced social interaction	
E2.	MOOD	One or more indicators of de	pressed, sad or anxious mood were	
	PERSIS- TENCE	not easily altered by attempt the resident over last 7 days	s to "cheer up", console, or reassure	
		No mood 1. Indicators pro indicators easily altered		
		inulcators easily differen	d not easily altered	

Numeric Identifier ____

OMB 0938-0739 expiration date 12/31/2002 MDS 2.0 PPS July 2002

Resident Identifier	Numeric Identifier
F4 REHAVIORAL (A) Rehavioral symptom frequency in last 7 days	G3 TEST FOR (Code for ability during test in the last 7 days)

E4.	BEHAVIORAL	(A) Behavioral symptom frequency in last 7 days			G3.	TEST FOR	(Code for ability during test in th	•	s)		
	SYMPIOMS	Behavior not exhibited in last 7 days					Maintained position as require Unsteady, but able to rebalan	ed in test	hout physical support		
		Behavior of this type occurred 1 to 3 days in last 7 days			ш	(see training manual)	2. Partial physical support during	g test;			
		2. Behavior of this type occurred 4 to 6 days, but less than daily			ш	,	or stands (sits) but does not for able to attempt test without				
		Behavior of this type occurred daily			ш		a. Balance while standing	at p.1.y 0.00			
		(B) Behavioral symptom alterability in last 7 days			Ш		b. Balance while sitting—position				
		Behavior not present OR behavior was easily altered			G4.	FUNCTIONAL	(Code for limitations during last	7 days th	at interfered with daily fund	ctions	or
		Behavior was not easily altered	(A)	(B)	ш	IN RANGE OF	placed residents at risk of injury (A) RANGE OF MOTION	(E) VOLUNTARY MOVEME	ENT	
		a. WANDERING (moved with no rational purpose, seemingly			ш	MOTION	No limitation Limitation on one side	0.	No loss Partial loss		
		oblivious to needs or safety)			ш		Limitation on both sides		Full loss	(A)	(B)
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)			ш		a. Neck	_			L
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others	\dashv		ш		b. Arm—Including shoulder or e				<u> — </u>
		were hit, shoved, scratched, sexually abused)			ш		c. Hand—Including wrist or finged. Leg—Including hip or knee	ers		\vdash	\vdash
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL			ш		e. Foot—Including ankle or toes			\vdash	\vdash
		SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public,			ш		f. Other limitation or loss				
		smeared/threw food/feces, hoarding, rummaged through others' belongings)			G5.	MODES OF LOCOMO-	(Check if applied during last 7 days))			
		e. RESISTS CARE (resisted taking medications/injections, ADL			ш	TION	b. Wheeled self				
		assistance, or eating)			G6.	MODES OF	(Check all that apply during last 7 d	ays)			
31 .		F-PERFORMANCE—(Code for resident's PERFORMANCE OVER A	\LL		ш	TRANSFER	a. Bedfast all or most of time				
		luring last 7 days —Not including setup) IDENT—No help or oversight —OR— Help/oversight provided only 1	or 2		ш		b. Bed rails used for bed				
		ng last 7 days	o. <u>-</u>		G7.	TASK	mobility or transfer Some or all of ADL activities we	re hroken	into subtasks during last 7	7	
	1. SUPERVI	(SION—Oversight, encouragement or cueing provided 3 or more times	s dur	ring	"	SEGMENTA-	days so that resident could perf				
	1 or 2 time	s —OR— Supervision (3 or more times) plus physical assistance proves during last 7 days	/laea	only	H1.		0. No 1. Yes E SELF-CONTROL CATEGORII	=0			
	2. LIMITED	ASSISTANCE—Resident highly involved in activity; received physical	help				ent's PERFORMANCE OVER ALL SHII				
	in guided	maneuvering of limbs or other nonweight bearing assistance 3 or molore help provided only 1 or 2 times during last 7 days	re tin	nes	ш	0. CONTINEN	NT—Complete control [includes t	ıse of indv	velling urinary catheter or o	ostom	ıv
		VE ASSISTANCE—While resident performed part of activity, over last	7-da	av	ш		does not leak urine or stool]		,		•
	period, he	lp of following type(s) provided 3 or more times:	. r uc	,			CONTINENT—BLADDER, incon	tinent epis	sodes once a week or less	;	
		-bearing support ff performance during part (but not all) of last 7 days			ш	BOWEL, les	ss than weekly				
	4. TOTAL DE	EPENDENCE—Full staff performance of activity during entire 7 days			ш	OCCASION BOWEL, or	VALLY INCONTINENT—BLADD	ER, 2 or r	nore times a week but not	daily;	
	8. ACTIVITY	/ DID NOT OCCUR during entire 7 days			ш						
	(B) ADL SUP	PORT PROVIDED—(Code for MOST SUPPORT PROVIDED OVER ALL					TLY INCONTINENT—BLADDEF sent (e.g., on day shift); BOWEL,			some)
	` SHIFTS dui	ring last 7 days; code regardless of resident's self-performance	(A)	(B)	ш	4 INCONTIN	ENT—Had inadequate control B	ADDER	multiple daily enisodes:		
	classificati 0. No setup	or physical help from staff	RF	L	Ш		(or almost all) of the time	D (DDLIN,	maniple daily episodes,		
	 Setup help 	p only	7	p	a.	BOWEL CONTI-	Control of bowel movement, wit	h appliand	ce or bowel continence		
	 One person Two+ person 	on physical assist 8. ADL activity itself did not occur during entire 7days	SELF-PERF	SUPPORT	Ш	NENCE	programs, if employed				
a.	BED	How resident moves to and from lying position, turns side to side,	0)	0)	b.	BLADDER CONTI-	Control of urinary bladder functi soak through underpants), with				
	MOBILITY	and positions body while in bed			Ш	NENCE	programs, if employed			\perp	
b.		How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)			H2.	BOWEL ELIMINATION	c. Diarrhea				
C.	MALK IN	, 31 (Ш	PATTERN	d. Fecal impaction				
_	ROOM	How resident walks between locations in his/her room			H3.	APPLIANCES AND	a. Any scheduled toileting planb. Bladder retraining program	\vdash	 d. Indwelling cathete i. Ostomy present 	er	
d.	WALK IN CORRIDOR	How resident walks in corridor on unit			ш	PROGRAMS	c. External (condom) catheter		i. Ostorny prosent		
e.	LOCOMO-	How resident moves between locations in his/her room and			Eor	Section I : che	eck only those diseases that ha	wo a rola	tionship to current ADL et	atus	
		adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair					ood and behavior status, medical				
f.		How resident moves to and returns from off unit locations (e.g.,			dea	th. (Do not list ir	nactive diagnoses)				
	TION OFF UNIT	areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on			11.	DISEASES	a. Diabetes melitus		v. Hemiplegia/Hemiparesis	s	_
		the floor. If in wheelchair, self-sufficiency once in chair					d. Arteriosclerotic heart	v	v. Multiple sclerosis		_
g.		How resident puts on, fastens, and takes off all items of clothing , including donning/removing prosthesis					disease (ASHD)	,	c. Paraplegia		
h	EATING	How resident eats and drinks (regardless of skill). Includes intake of					f. Congestive heart failure		z. Quadriplegia		
		nourishment by other means (e.g., tube feeding, total parenteral					j. Peripheral vascular disease	ee	e. Depression		
		nutrition) How resident uses the toilet room (or commode, bedpan, urinal);					m. Hip fracture	f	 f. Manic depressive (bipola disease) 	ar	
		transfer on/off toilet, cleanses, changes pad, manages ostomy or					r. Aphasia	- 00	J. Schizophrenia		
_		catheter, adjusts clothes					s. Cerebral palsy		n. Asthma	\vdash	_
j.	HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face,					t. Cerebrovascular accident		ii. Emphysema/COPD		
_		hands, and perineum (EXCLUDE baths and showers)			Ш		(stroke)				
G2.		How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and			12.	INFECTIONS	(If none apply, CHECK the NONE OF		,	_	_
		hair.) Code for most dependent in self-performance.					a. Antibiotic resitant infection (e.g. Methicillin resistant		. Septicemia . Sexually transmitted		
		(A) BATHING SELF PERFORMANCE codes appear below		(A)			staph)	n.	diseases		
		Independent—No help provided Supervision—Oversight help only					b. Clostridium difficile (c. diff.)	i.	. Tuberculosis		
		Physical help limited to transfer only					c. Conjunctivitis	j.	. Urinary tract infection in last 30 days		
		Physical help in part of bathing activity					d. HIV infection e. Pneumonia	k	. Viral hepatitis		_
		4. Total dependence					f. Respiratory infection		. Wound infection		_
		Activity itself did not occur during entire 7 days			Ш		Acophatory infection	m	. NONE OF ABOVE		

Resident Identifier ______ Numeric Identifier _

I3.	OTHER CURRENT			M2.	TY
	DIAGNOSES	a.			01
	AND ICD-9 CODES	b.			
J1.	PROBLEM CONDITIONS	(Check all problems present in last 7 days unless other indicated)	time frame is		
		INDICATORS OF FLUID STATUS OTHER e. Delusions		M3.	HIST
		a. Weight gain or loss of 3 or g. Edema			UL
		more pounds within a 7- h. Fever		M4.	OTHE
		day period i. Hallucinat	ions		PRO OR L
		b. Inability to lie flat due to shortness of breath j. Internal bl	<u> </u>		PRI
		c. Dehydrated; output last 90 da	· —		(Check apply of last 7 of
		d. Insufficient fluid; did NOT consume all/almost all liquids provided during last 3 days			last I C
J2.	PAIN	(Code the highest level of pain present in the last 7 day	s)	M5.	
	SYMPTOMS	a. FREQUENCY with which b. INTE	NSITY of pain		TF MI
		resident complains or shows evidence of pain 1. Mild p	ain		(Chec
			rate pain		apply
		1 Pain less than daily 3. Times	when pain is horrible		last 7
		2. Pain daily	uorauriy		
J4.	ACCIDENTS	(Cricon an anal apply)	in last 180 days		
		days	ure in last 180		
		b. Fell in past 31-180 days e. NONE OF	ABOVE		
J5.	STABILITY	a. Conditions/diseases make resident's cognitive, AD	DL, mood or	<u></u>	
	OF CONDITIONS	b. Resident experiencing an acute episode or a flar		M6.	PRO AND
		or chronic problem			(Chec
		c. End-stage disease, 6 or fewer months to live			apply
K1.	ORAL	d. NONE OF ABOVE a. Chewing problem			lást 7
K1.	PROBLEMS	b. Swallowing problem			
K2.	HEIGHT	Record (a.) height in inches and (b.) weight in pound			
	AND WEIGHT	recent measure in last 30 days ; measure weight co standard facility practice—e.g., in a.m. after voiding,	onsistently in accord with before meal, with shoes	N1.	Т
		off, and in nightclothes		'''	AV
		a. HT (in.)	b. WT (lb.)		
K3.	WEIGHT CHANGE	a. Weight loss—5 % or more in last 30 days; or 10 180 days	% or more in last		
		0. No 1. Yes		(If	reside
		b. Weight gain—5 % or more in last 30 days; or 10) % or more in last	N2.	AVE
		180 days			INVO
<u> </u>		0. No 1. Yes			ACT
K5.	NUTRI- TIONAL	(Check all that apply in last 7 days)	James described	01.	ME
	APPROACH-		planned weight e program	<u> </u>	Т
	ES	b. Feeding tube		03.	INJE
K6.	PARENTERAL			04.	D
	OR ENTERAL INTAKE	a. Code the proportion of total calones the resider	t received through		REC
		parenteral or tube feedings in the last 7 days 0. None 3. 51% to 75%			FOLI
		1. 1% to 25% 4. 76% to 100	%		MED
		2. 26% to 50%	uha in leet 7 deus	<u></u>	
		b. Code the average fluid intake per day by IV or to 0. None 3. 1001 to 150		P1.	SP
		1.1 to 500 cc/day 4.1501 to 200	0 cc/day		MI
M1.	ULCERS	2.501 to 1000 cc/day 5.2001 or mo (Record the number of ulcers at each ulcer stage—	regardless of		DUR
"""	(Due to any	cause. If none present at a stage, record "0" (zero). during last 7 days. Code 9 = 9 or more.) [Requires			PRO
	cause)	Stage 1. A persistent area of skin redness (without skin) that does not disappear when pre	out a break in the		
		b. Stage 2. A partial thickness loss of skin layers th clinically as an abrasion, blister, or shall	at presents		
		c. Stage 3. A full thickness of skin is lost, exposing tissues - presents as a deep crater with			
1					I
		undermining adjacent tissue. d. Stage 4. A full thickness of skin and subcutaneo exposing muscle or bone.	us tissue is lost,		

_					
M2.	TYPE OF ULCER	(For each type of ulcer, code for the highest stage in the last 7 days using scale in item M1—i.e., 0=none; stages 1, 2, 3, 4)			
		Pressure ulcer—any lesion caused by pressure damage of underlying tissue	resulting in		
		b. Stasis ulcer—open lesion caused by poor circul extremities	ation in the lower		
М3.		Resident had an ulcer that was resolved or cured in	n LAST 90 DAYS		
	RESOLVED ULCERS	0. No 1. Yes			
M4.	OTHER SKIN	a. Abrasions, bruises			
	PROBLEMS OR LESIONS	b. Burns (second or third degree)			
	PRESENT	c. Open lesions other than ulcers, rashes, cuts (e.g			
	(Check all that	d. Rashes—e.g., intertrigo, eczema, drug rash, he zoster	at rash, herpes		
	apply during last 7 days)	e. Skin desensitized to pain or pressure			
	,	f. Skin tears or cuts (other than surgery)			
		g. Surgical wounds			
	OKINI	n. NONE OF ABOVE			
M5.	SKIN TREAT-	a. Pressure relieving device(s) for chair			
	MENTS	b. Pressure relieving device(s) for bedc. Turning/repositioning program			
	(Check all that	d. Nutrition or hydration intervention to manage sk	in problems		
	apply during last 7 days)	. Ulcer care			
		Surgical wound care			
		. Application of dressings (with or without topical medications) other than to feet			
		Application of ointments/medications (other than to feet)			
		Other preventative or protective skin care (other than to feet)			
		NONE OF ABOVE			
M6.	FOOT	a. Resident has one or more foot problems—e.g., corns, callouses,			
	PROBLEMS AND CARE	bunions, hammer toes, overlapping toes, pain, structural problems b. Infection of the foot—e.g., cellulitis, purulent drainage			
	(Check all that	c. Open lesions on the foot	age		
	apply during last 7 days)	d. Nails/calluses trimmed during last 90 days			
	,, u, u,	e. Received preventative or protective foot care (e. shoes, inserts, pads, toe separators)	g., used special		
		f. Application of dressings (with or without topical medications)			
		g. NONE OF ABOVE	,		
N1.	TIME AWAKE	(Check appropriate time periods over last 7 days) Resident awake all or most of time (i.e., naps no m	ore than one hour		
		per time period) in the:			
		a. Morning c. Evening b. Afternoon d. NONE OF ABO	OVE		
(lf ı	resident is co	omatose, skip to Section O)			
N2.	AVERAGE	(When awake and not receiving treatments or	· · · · · · · · · · · · · · · · · · ·		
	TIME INVOLVED IN ACTIVITIES	1. Some—from 1/3 to 2/3 of time 3. None	than 1/3 of time		
01.	NUMBER OF MEDICA- TIONS	(Record the number of different medications used in the "O" if none used)	he last 7 days; enter		
03.	INJECTIONS	(Record the number of DAYS injections of any type re-	ceived during the		
04.	DAYS	last 7 days; enter "0" if none used) (Record the number of DAYS during last 7 days; enter "	011 16		
04.	RECEIVED	Note—enter "1" for long-acting meds used less th			
	THE FOLLOWING	 	ypnotic		
	MEDICATION		iuretic		
<u></u>	ODEOLAL	c. Antidepressant			
P1.	SPECIAL TREAT- MENTS,	a. SPECIAL CARE—Check treatments or prog during the last 14 days	rams received		
	PROCE- DURES, AND	TREATMENTS PROGRAM	s		
	PROGRAMS		drug treatment		
		b. Dialysis program			
		care unit	er's/dementia special		
		d. Intake/output e. Monitoring acute medical o. Hospice	care		
		condition p. Pediatric	unit		
		f. Ostomy care q. Respite			
		return to	in skills required to the community		
		h. Radiation (e.g., tak	ing medications, ork, shopping,		
			tation, ADLs)		
		1	F THE ABOVE		
		I. Ventilator or respirator			

Resi	dent Identifier_					
P1.	SPECIAL TREAT- MENTS, PROCE-	b. THERAPIES - Record the number of days and total min following therapies was administered (for at least 15 min calendar days (Enter 0 if none or less than 15 min. dai [Note — count only post admission therapies]	nutes a			st 7
	DURES, AND	(A) = # of days administered for 15 minutes or more	DAYS		IIN	
	PROGRAMS	(B) = total # of minutes provided in last 7 days	(A)	(B)	\vdash

	MENTS, PROCE- DURES, AND PROGRAMS	[Note — count only pos	for 15 minutes or more	DAYS (A)	IIN B)	
		a. Speech - language patho	logy and audiology services			
		b. Occupational therapy				
		c. Physical therapy				
		d. Respiratory therapy				
		 e. Psychological therapy (by professional) 	any licensed mental health			
P3.	NURSING REHABILITA- TION/ RESTOR-	Record the NUMBER OF restorative techniques or p more than or equal to 15 (ENTER 0 if none or less t	oractices was provided to i is minutes per day in the l a	he resid	lents for	•
	ATIVE CARE	a. Range of motion (passive)	f. Walking			
		b. Range of motion (active)	g. Dressino	g or groom	ing	
		c. Splint or brace assistance	h. Eating o	r swallowir	na	
		TRAINING AND SKILL PRACTICE IN:	i. Amputat			
		d. Bed mobility	j. Commur	ication		
		e. Transfer	k. Other			
P4.	DEVICES	Use the following codes fo	r last 7 days:			
	AND RESTRAINTS	0. Not used				
		Used less than daily				
		2. Used daily				
		Bed rails				
		a. —Full bed rails on all or	pen sides of bed			

b. —Other types of side rails used (e.g., half rail, one side)

e. Chair prevents rising
 In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) examined the resident? (Enter 0 if none)

c. Trunk restraint d. Limb restraint

PHYSICIAN VISITS

		Numeric Identifier
P8.		In the LAST 14 DAYS (or since admission if less than 14 days in facility) how many days has the physician (or authorized assistant or practitioner) changed the resident's orders? Do not include order renewals without change. (Enter 0 if none)
Q1.	DISCHARGE	a. Resident expresses/indicates preference to return to the community
	OTENTIAL	0. No 1. Yes
		c. Stay projected to be of a short duration—discharge projected within 90 days (do not include expected discharge due to death) 0. No 2. Within 31-90 days 1. Within 30 days 3. Discharge status uncertain
Q2.	OVERALL CHANGE IN CARE NEEDS	Resident's overall level of self sufficiency has changed significantly as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved—receives 2. Deteriorated—receives
		fewer supports, needs more support less restrictive level of
R2	SIGNATURE (care CORDINATING THE ASSESSMENT:
	Olona ii one i	, I Ellouis Goot Bird time The Adolescinetti
a. S	ignature of RN A	ssessment Coordinator (sign on above line)
		nent Coordinator
SI	igned as comple	Month Day Year
T1.	SPECIAL TREATMENTS	Skip unless this is a Medicare 5 day or Medicare readmission/return assessment
	AND PROCE- DURES	b. ORDERED THERAPIES—Has physician ordered any of the following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service? 0. No 1. Yes
		c. Through day15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.
		1
		d. Through day15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered.
		therapy minutes (across the therapies) that can be

Resident	Numeric Identifier

MINIMUM DATA SET (MDS) - VERSION 2.0 FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

SECTION W. SUPPLEMENTAL MDS ITEMS

1.	National Provider ID	Enter for all assessments and tracking forms, if available.		
If the ARD of this assessment or the discharge date of this discharge tracking form is between July 1 and September 30, skip to W3.				
2.	Influenza Vaccine	 a. Did the resident receive the Influenza vaccine in this facility for this year's Influenza season (October 1 through March 31)? 0. No (If No, go to item W2b) Yes (If Yes, go to item W3) b. If Influenza vaccine not received, state reason: Not in facility during this year's flu season Received outside of this facility Not eligible Offered and declined Not offered Inability to obtain vaccine 		
3.	Pneumo- coccal Vaccine	 a. Is the resident's PPV status up to date? 0. No (If No, go to item W3b) 1. Yes (If Yes, skip item W3b) b. If PPV not received, state reason: 1. Not eligible 2. Offered and declined 3. Not offered 		